

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Webinar 7: Quality Measurement and Data Collection Special Issues– Part 2 of 2

Presented by the Substance Abuse and
Mental Health Services Administration
August 23, 2016



Speakers

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Logistics

- Questions and chat function
- Poll questions

Webinar Schedule

- 1: July 12: Introduction and Background – **States and BHCs**
- 2: July 19: State-Reported Measures – **States Only**
- 3: July 26: State-Reported Measures – **States Only**
- 4: August 2: Clinic-Reported Measures – **States and BHCs**
- 5: August 9: Clinic-Reported Measures – **States and BHCs**
- 6: August 16: Special Issues – **States and BHCs**
- 7: August 23: Special Issues – **States and BHCs**
- 8: September 6: Non-Required Measures – **States Only**

All scheduled for Tuesdays 2:00 to 3:30 pm ET

Focus Today

Quality Bonus Measures and Payments
Lessons learned from state visits
Outstanding questions

Quality Bonus Measures Used for Section 223 Behavioral Health Demonstration Payment

Contents

- **The measures used for Quality Bonus Payments (QBPs)**
- **Setting measurement targets**
- **Determining baseline data**
- **State considerations for payment**
- **Timing of QBP**
- **QBPs and dually eligible beneficiaries**
- **State access to dually eligible beneficiary data**
- **Quality Bonus Measure resources**

Required Quality Bonus Payment Measures

Acronym	Measure	Measure Steward	QBP Eligible Measures	Required QBP Measures
FUH-BH-A	Follow-Up After Hospitalization for Mental Illness (adult age groups)	NCQA	Yes	Yes
FUH-BH-C	Follow-Up After Hospitalization for Mental Illness (child/adolescents)	NCQA	Yes	Yes
SAA-BH	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA	Yes	Yes
IET-BH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	Yes	Yes
SRA-A	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
SRA-BH-C	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes

For the state to make QBP, the CCBHC must demonstrate that it has achieved all of the required quality measures

Current Additional Optional QBP Measures

Acronym	Measure	Measure Steward	QBP Eligible Measures	Required QBP Measures
ADD-BH	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA	Yes	No
CDF-BH	Screening for Clinical Depression and Follow-Up Plan	CMS	Yes	No
AMM-BH	Antidepressant Medication Management	NCQA	Yes	No
PCR-BH	Plan All-Cause Readmission Rate	NCQA	Yes	No
DEP-REM-12	Depression Remission at Twelve Months-Adults	MCM	Yes	No

The state can make QBP using the additional optional measures provided in the guidance, but only after the CCBHC has met performance goals for the required set of bonus measures.

The state also can suggest additional measures for QBPs.

Setting QBP Measurement Targets

- States must set measurement targets for determining whether quality measures have been achieved, making a provider eligible for a QBP.
- States have flexibility in setting measurement targets; there are no measurement targets prescribed for this demonstration.
- Measurement targets should be set to address health needs identified by the state. For example, a state can utilize its needs assessment to develop targets.
- Measurement targets should be equitable among all certified clinics.
- Measurement targets should meaningfully promote quality improvement by all CCBHCs.
- When completing section 2.1.b of its demonstration application, the state will describe its QBP measurement targets as factors that trigger payment.

Setting Targets

- **A measurement target may be based on attainment or improvement but should incentivize better quality of care.**
 - *Rewarding attainment encourages those below a standard to reach it.*
 - *Rewarding improvement not only encourages improvement but also encourages continued improvement among those already doing well.*
 - *A state can use both.*
- **Set targets in light of available data**
- **The target for DY1 will be relative to the baseline selected by the state and may be as simple as a rate the state determines is reasonable (e.g., top 50% or 75% of the CCBHCs in the state).**
- **The target for DY2 will be based on DY1 results**

Determining Baseline Data

- **States need baseline data for each year and targets for each year.**
- **Baselines for DY1, possible approaches:**
 - *For HEDIS measures, may base on existing statewide information*
 - *For Medicaid Core Set measures, may base on existing results*
 - *If administrative measures, existing data for the BHC*
 - *Data collected since the planning grant began (even if not a full year)*
 - *First 3 or 6 months of DY1*
 - *Recent year rates from other sources*
- **Baselines for DY2→ DY1 results**

State Considerations for Payment

- **To receive a QBP the provider must achieve on all six of the required measures.**
- **Retain flexibility for target modification**
 - *Application will provide preliminary approach to target setting*
 - *Flexibility is allowed if preliminary target is unreasonable*
- **No payment is allowed prior to achievement of measures**
- **For a lump sum QBP, the state must allocate the cost of the payment using the FMAPs specified in section 223 d(5) of the PAMA.**
- **Timing of payment**
- **Availability of data**

Timing of QBP Payment

- **Timing of payment is determined by the state and will be affected by the availability of quality data. (See Measurement Period tables in specifications at Appendix A, and tables in data template)**
- **Annual payment after submission of quality measures data to SAMHSA is one simple option**
 - *SAMHSA specifies that CCBHCs submit quality data within 9 months after the end of each DY to the state.*
 - *The state is required to submit quality data within 12 months after the end of each DY to SAMHSA.*
- **More frequent reporting can allow earlier determination of progress and an increased opportunity for implementing improvement.**

QBP's and Dually Eligible Beneficiaries

- **States and clinics are expected to report data for dually eligible beneficiaries**
 - *Clinics report for all of their consumers*
 - *States report for Medicaid only and dually eligible consumers*
- **In assessing achievement of a QBM the state may elect to include data on: (1) all dually eligible beneficiaries, or (2) only Specified Low-Income Medicare Beneficiaries (SLMB) and Qualified Medicare Beneficiaries (QMB).**

State Access to Data on Dually Eligible Beneficiaries

- **States should continue to access data for dually eligible beneficiaries in the same manner used for determining cost sharing.**
- **Availability of data varies and depends on:**
 - *Whether it is Medicare managed care data*
 - *Whether beneficiaries are part of the Coordination of Benefits Financial Alignment Initiative*
 - *Whether it is Part D data**
- **States should report all data to the extent possible and specify in the data reporting template any variances in reporting.**

* See <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/GuidePartDv3-3-17-09-2.pdf>

Quality Bonus Measure Resources

- **Section 223 RFA: Criteria and PPS Guidance:**
 - *See sections 2.1b, 2.2b, and Table 3 of **Appendix III – PPS Guidance** for information related to setting quality bonus payments for PPS-1 and PPS-2.*
 - *See **SAMHSA Criteria Appendix A: Quality Measures and Other Reporting Requirements** for a list of required data and quality measures.*
- **CMS TA Webinar 8: Quality Bonus Payment**
- **Section 223 Quality Measures Website**
 - *Technical Specifications Manual*
 - *Data-Reporting Templates*
- **CMS mailbox for Quality Based Payment-related questions:**
MACQualityTA@ccms.hhs.gov

Questions?

State Visits – Lessons Learned

Site Visits

- **SAMHSA's contractor, Truven Health Analytics, visited 3 states to determine how best to structure these 8 technical assistance webinars.**
- **Contractor met with state officials and providers.**
- **SAMHSA was not informed of which states were visited to prevent any potential effect on the selection of states for the CCBHC demonstration program.**
- **The lessons learned can be useful whether or not the state is a part of the CCBHC demonstration program, for example as other initiatives involving quality measures are implemented.**

Selection Criteria for Visits

From a group of volunteers:

- Geographic representation by region
- Predominantly urban vs rural vs mixed
- Many vs few BHCs expected to be certified
- Different levels of integration of mental health and substance use disorder treatment
- Different levels of managed care penetration
- Special populations of interest



Road Map for Implementation



Road Map for Implementation (1)



Step 1 – Review the Measures

- Which measures are new for you and which are you already collecting?
- Build on and learn from current quality measure activity in your state for other programs, for example:
 - FQHCs
 - Meaningful use
 - Health homes

Road Map for Implementation (2A)



Step 2A – Map Data Systems

Map the data systems that will need to talk to each other to generate the quality measures

- How centralized are the data collection and reporting systems in your state?
- Determine EHR capabilities:
 - Are the data fully accessible? Review contracts if hosted elsewhere.
 - Are the EHR systems flexible to adaptation?
 - Are BHC EHRs compatible with state systems?
 - Can the EHR vendor easily and quickly program for the new measures?
 - Can the BHC easily program, if necessary?
- Will new measures require hand entry or batch entry?
 - Will you need to develop a mixed system with some hand entry and some automated (e.g., for DCOs)?

Road Map for Implementation (2B)



Step 2B – Interdisciplinary Working Groups

- **Pull together interdisciplinary working groups at the state and BHC level to review measures and map systems.**
- **Potential participants:**
 - **State:** State Medicaid and behavioral health agencies, state IT and data analytics personnel, quality specialists, Medicaid managed care representatives, external quality review organization (EQRO) representatives, BHC representatives
 - **BHC:** Develop a quality leadership team that includes CEO, clinic administrators and operations personnel, quality representatives, IT staff, providers
- **Try to assure consistency in teams over time**

Road Map for Implementation (3)



Step 3 – IT Quality and Testing

Develop and implement IT quality and testing protocols

- For hand entry, identify fields that can include built-in quality checks (data validation)
- Leave time to test and refine systems
- Integrate provider feedback into systems development
- Establish a data flow workgroup that vets changes and crosschecks reports with information in the software
- Integrate a process that allows interim reporting and feedback prior to year-end

Road Map for Implementation (4)



Step 4 – Data Collection Training

Develop and implement data collection training protocols

- *Consider provider buy-in in the BHC*
- *Streamline new data collection into existing systems whenever possible*
- *Develop training protocols and mechanisms for feedback loops to IT staff*
- *Provide regular feedback to providers on results of data collection and quality measure processes.*
- *Use these webinars as a basis for developing your training*

Road Map for Implementation (5)



Step 5 -- Continuous Quality Improvement



Things to think about as you plan implementation

Think About

For States: Attribution of a client to a BHC in the state data

For States: Timeliness and access to data on dually eligible

For States: Degree of MCO penetration, movement of individuals among MCOs, and access to data for the eligible population

For States: Effects of PPS or Managed Care:

- *How to accurately report encounters if payment is bundled?*

For BHCs and States: DCOs:

- *Obtaining the data:*
 - Will BHCs have them enter into their system, provide data another way, or is the information available to the state directly from the DCOs?

For BHCs and States: Do data actually reflect what is happening on the ground?

- *Coding for SA diagnoses*
- *Coding of certain HCPCS G codes*

As You Approach the Task (1)

Consider clinic burden

- *Is there duplication of data entry for providers across multiple systems?*

Build an interdisciplinary team

- *Understand problems and systems development through multiple lens*
- *Make an effort to understand the different perspectives*

Consider how 42 CFR Part 2 will affect decisions

- *Are SU and MH data unified or separate?*
- *Can the state calculate measures capturing the entire relevant population if the data are separate?*
- *Bring the different agencies together*

As You Approach the Task (2)

Don't short-change the planning process

- Build in the necessary meetings and processes to develop the system
- Be patient with the process of identifying and fixing glitches in the system

Consider efficiencies

- Do you want to create systems for just CCBHCs or for a larger number of BHCs in your state?
- Do you want to collect the data on all clients and carve out CCBHC clients for reporting?
- Leverage current data systems at the state and clinic level as much as possible in development of the BHC QM system

Bigger is not necessarily better

- Consider flexibility of your data systems to tweak the coding needed to capture the measures

BHC-Level Considerations

- **Timeline for completing necessary processes**
 - *Develop data systems*
 - *Program specs*
 - *Test and validate systems*
 - *Train providers*
 - *Ensure consistency in provider entry*
- **Collaboration at a clinic level**
 - *Interdisciplinary planning teams (e.g., administrators, IT providers, clinicians)*
 - *Feedback loops from IT to providers and back again*
 - *Consistency in membership on teams over time*

Keep the Quality Measure Process in Perspective

- **There is never a perfect measure**
- **Use measures to represent the activities happening on the ground as closely as possible**
- **Although not perfect, measures can be used to improve care.**

For example:

- *Shining a spotlight on systems improvements (e.g., integration of care for physical and behavioral health issues)*
- *Improved coordination of care after ED visits or hospitalization*
- *Consistent medication management*

Poll Question

August 23, 2016: How ready do you believe you are to implement the quality measure process? (totally anonymous!!)

- *Not at all*
- *Somewhat*
- *OK given the time we have left*
- *Good*
- *Great*
- *I'd rather not say*

Questions?

Outstanding Questions

Question: Accessing Earlier Webinars

Question: How can I access the slides to the webinars previously held that I was unable to attend?

- The slides are available for download as a pdf on the webinar site, and the webinar itself can be viewed on demand on that site. You do, however, need to register for each webinar separately. The webinars also will be on the SAMHSA website once they are posted at <http://www.samhsa.gov/section-223/webinars>*

Question: Qualified Medicare Beneficiaries (QMBs)

Question: Would Medicaid QMB and QMB Plus beneficiaries be defined as Medicaid/Medicare dually eligible or as Medicare beneficiaries for purposes of stratification and quality bonus payment? QMBs equals Medicaid pays for their Medicare premiums, but does not cover a service that's not covered by Medicare.

Both QMBs and QMB Plus beneficiaries are treated as dually eligible for purposes of stratification.

Question: Reporting Delayed Claims

Question: Providers have up to one year to file a Medicaid claim. What does this mean for CCBHC reporting deadlines? We know that the states have up to a year after the demonstration year ends to submit the quality measures. What do we do if we get claims after that point?

As part of Medicaid rules, states have up to 2 years to make claim adjustments under the 2-year timely filing rule. Although the states might have additional time to seek reimbursement after the year in which data must be reported for the demonstration, evaluation time constraints mean that, for the measures, the data available by the one year deadline for submission are what will be used for the evaluation.

Question: Data Validation

Question: What validation of quality measure rates submitted will occur?

BHCs and the states should be engaged in data and measure result validation although there is no specific requirement for such in the criteria. Neither SAMHSA nor CMS will be validating the results reported by the CCBHCs or states as part of the demonstration program.

Question: Formal Agreements with EDs

Question: Measures assume CCBHCs will monitor customer use of EDs and follow up as needed. Does SAMHSA have examples of formal agreements that CCBHCs enter into with EDs about shared data for care coordination purposes (e.g., client ID and diagnosis from ED visits)?

SAMHSA does not have examples of such agreements. Much of the information provided earlier about agreements with DCOs may be applicable. Also, although it is a different realm, the Accountable Care Organizations (ACOs) have been working on this, and it is something that requires persistence and flexibility to find a process that works. One thing that has helped is to have agreements with hospitals to assure that providers know that there has been an admission. That is very important and the criteria do call for care coordination agreements. BHCs will need to enter into such agreements with facilities most likely to be their care coordination partners. (continued next slide)

Question: Formal Agreements with EDs (cont'd)

Such agreements might call for some or all of:

- 1) designation of individuals on both sides who will be responsible for alerting and receiving information related to ED use;*
- 2) provision for inquiry of individuals seen in EDs for psychiatric or substance use purposes if they are BHC consumers;*
- 3) provision for releases of information that allow information sharing regarding the ED visit; and*
- 4) provision for care coordination meetings to advance the processes and systems of care coordination.*

Other provisions might be included as well. Many hospitals will already be in a position of needing to better coordinate after-care and overtures and agreements such as this may actually be welcomed by hospitals as a way to facilitate that. The FMAP for enhancing Health Information Exchange (HIE) for non-eligible providers in order to help eligible providers meaningfully use EHRs may play into this.

Question: Medicaid Enrollee Services Without Medicaid Claims Data

Question: For measures such as the one for follow-up after a person is seen at the emergency department for alcohol or other drug dependence treatment, what if the person is a Medicaid enrollee but is seen in a residential treatment program or some other substance use disorder program that is not paid for by Medicaid in our state? The data will not be available as Medicaid claims data.

If the Medicaid enrollee is seen somewhere that is not captured in the claims data, the BHC or state should indicate that the data are not available and why (use the data reporting templates sections E and F).

Question: I-EVAL – First Contact

Question: For the measure related to timing of initial evaluation, what is the definition of first contact?

For this measure, it is important to remember that we are looking back 6 months before the time they are seen to determine if they are “new.” Assuming that this is someone not seen at the BHC in the past 6 months, first contact usually will be a call looking for an appointment or a walk-in looking for an appointment. A first contact also could be a crisis service provided by the BHC. The certification criteria (2.b.1) require that, at first contact, there be a preliminary screening and risk assessment to ascertain acuity of needs. Depending on the results, the first service and initial evaluation is required within 10 business days if needs are routine. If needs are urgent, the initial evaluation and service must be within one business day. If the needs constitute an emergency, “appropriate action must be taken at once.” An initial evaluation, as defined in 4.d.3, should be incorporated into the emergency evaluation process conducted by the CCBHC.

Question: I-EVAL -- Inpatient Prescreen

Question: If someone receives an inpatient prescreen and there's a call later for services, would this be considered a new consumer?

The inpatient prescreen would qualify a person as a CCBHC consumer if the CCBHC included the preliminary screening and risk assessment and gathered other basic information about the person. They would be a new consumer if they had not been provided services by the CCBHC in the past 6 months. An initial evaluation should then be conducted within 10 days, sooner if they meet certain characteristics indicated in the certification criteria at 2.b.1.

Question: I-EVAL – Open Access

Question: If a program has open access where clients can come in whenever they want during certain hours, but they happen to call first to determine what the open access hours are, is that call considered first contact?

No, a call to determine when open access hours are held is not first contact unless that call is accompanied by the preliminary screening and risk assessment and collection of basic data about the person, including insurance information. In, general, however, if a person calls just to find out what hours you are open, that is not an initial contact. That is an attempt to find out when they can come in and have an initial contact.

Question: If a consumer calls seeking an evaluation and we provide them with our own open access and they never show, is that counted in the denominator?

Yes, assuming you performed the required preliminary screening and risk assessment to ascertain level of acuity when they called.

Question: I-EVAL – PCP Referral

Question: Is a PCP referral considered the first point of contact?

No, it has to be a contact by the person who's seeking services or by their family if they're a child. The first point of contact is the person seeking services so their acuity of needs can be determined using the preliminary screening and risk assessment that is supposed to occur at first contact.

Question: I-EVAL – Detox

Can your first contact be entering into Level III detox (if it is part of the CCBHC) and then they enter into follow-up outpatient care within ten days?

Level III detox that is either inpatient or residential is not a CCBHC demonstration service. If there is a prescreen at the detox that satisfies the requirements of making someone a CCBHC consumer (preliminary screening and risk assessment by the CCBHC), then the results of that regarding acuity of need would govern when the initial evaluation must be performed.

Question: Screening for Clinical Depression & Follow-up – PHQ-A

Question: For the measure of screening for clinical depression and follow-up planning, I see PHQ-9 Listed. For kids, can the PHQ-A be used?

The PHQ-A is a standardized instrument designed for adolescents and was developed by those who developed the PHQ-9. It is always preferable to use an age-appropriate instrument and the measure does not limit instruments that can satisfy the numerator to those listed in the definition of a standardized instrument; rather, it only requires that the screening tool be standardized.

Question: Screening for Clinical Depression & Follow-up – Interpretation (1)

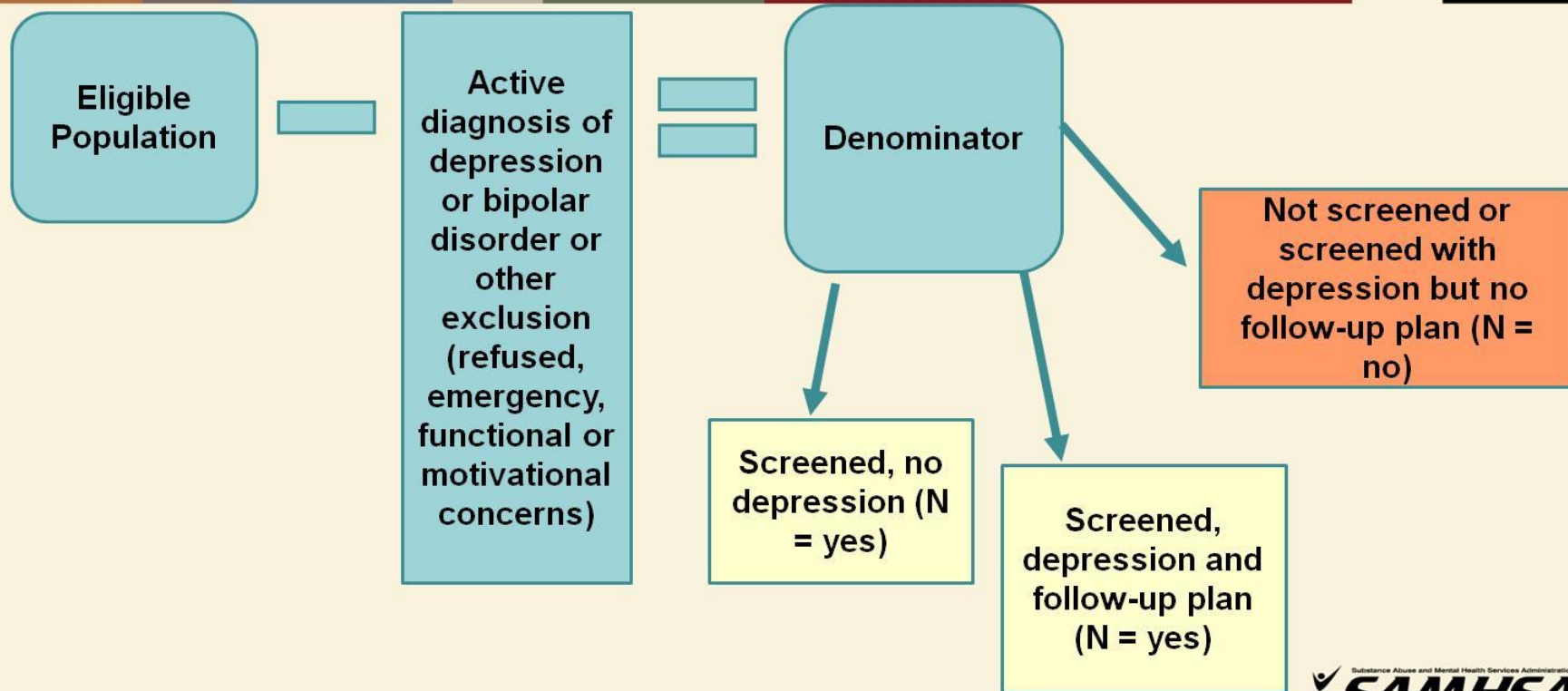
Question: For the measure of screening for clinical depression and follow-up planning, would it be viewed positively if all who scored positive on the scale were excluded due to active diagnosis of depression?

During the webinars, we always try to explain how the rate achieved on the measure is related to quality. Here, a higher rate of screening and, where needed, follow-up planning is associated with higher quality because the goal is to consistently screen recipients of services at the BHCs for depression and provide follow-up if the screen indicates it is needed. This is designed to improve identification of those in need and the provision of necessary services. (cont'd)

Question: Screening for Clinical Depression & Follow-up – Interpretation (2)

The question seems to assume that the BHC can screen individuals and then, if they are found to have depression, exclude them from the denominator. That is not how the active diagnosis of depression comes into play and would defeat the purpose of the measure. Rather, because the purpose of the measure is to encourage the new identification of depression with resulting treatment, those who are already diagnosed with depression or bipolar disorder are excluded from the measure completely so you are only capturing those without an active diagnosis. From those, you conduct screening and, if depression is found, you provide follow-up planning. Those counted in the numerator are the subset of those who are not excluded because of existing diagnosis or other exclusion criteria, who are either: 1) screened and found not to have depression or 2) screened and found to have depression and then provided follow-up planning.

Question: Screening for Clinical Depression & Follow-up – Interpretation (3)



Question: Screening for Clinical Depression & Follow-up – Eligible Encounters

Question: For the measure of screening for clinical depression and follow-up planning, how do you define an encounter? Is it any provider, therapist, MD, NP, PA?

The codes that indicate whether there is an eligible encounter that will get the person into the denominator are provided in the source measure. They include codes for services that a psychiatrist, masters level clinician, psychologist, primary care physicians, or others might utilize. You should review the source measure link in section A of the specification to ascertain precise codes and who, within the licensure and other requirements applicable, can provide the “eligible encounter.”

Question: Screening for Clinical Depression & Follow-up – Coding (1)

Question: If the consumer is receiving therapy, how can they use the codes in conjunction with the therapy codes for screening and planning?

For the eligible encounter that gets them into the denominator (and which is the encounter in which the numerator screening and planning are to occur), you should look at the codes that the specification identifies for the eligible population. They are located in the source measure linked in section A of the specification. For the G codes that are used to indicate numerator compliance or noncompliance, it appears that not all states have them turned on. This may be an overly simplistic answer but some options would be for the state to turn them on for the BHCs or for clinics to find ways to modify their EHR to accommodate the codes for internal purposes, training clinicians to use them, and then using them to calculate the measure.

Question: Screening for Clinical Depression & Follow-up – Coding (2)

Question: For the measure of screening for clinical depression and follow-up planning, if we incorporate codes, can you use sampling from the baseline year since the codes are not currently being used?

First, you will use billing (encounter) data from the measurement year (DY for CCBHCs) to develop the eligible population/denominator. Second, for the numerator, whether you sample or use the entire eligible population, you also use data from the measurement year. So if, prior to DY1, you did not use the G codes, but you begin using them in DY1, you will have what you need. If you do not have the codes in place, you will need to do a more detailed record review.

Question: Adult BMI – Use of Medical Assistants

For the adult BMI measure, the state of Michigan does not have a billable code for medical assistants to take BMI vitals on the BH side of the CCBHC. Would MAs be allowed to take vital signs for BMIs?

There is nothing in this measure that specifies what kind of provider it has to be beyond the required use of encounter codes to establish the eligible population visits for the denominator. This raises two questions: (1) is there anything in state licensing laws that preclude an MA from taking vital signs for BMIs? (2) Within the CCBHC demonstration program, can a CCBHC treat it as an encounter for purposes of the PPS and Medicaid reimbursement? Because the state plan does not limit the provision of CCBHC services as part of the demonstration program, that alone should not be an impediment.

Comments Related to G Codes

In response to the discussion on the Screening for Clinical Depression and Follow-up Plan measure (and similar measures):

- Our state does not have these codes
- Our state will not let behavioral health providers use these codes
- Getting clinicians to use the codes consistently is difficult and the data will be inaccurate
- “Really! Providers changing practice? Even if you do teach them the codes, or, give them a cheat sheet it’s not a sure thing. You still have to sample to audit compliance.”
- Our system does not allow a way to add reportable codes to services. We use Structured Query Language (SQL) to pull data and assign the appropriate HCPCS code

Upcoming Webinar Schedule

8: September 6: Non-Required Measures – States Only
Tuesday 2:00 to 3:30 pm ET

BHC Measures (1)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
SSD	State	✓	n/a	2
SAA-BH	State	✓	n/a	2
ADD-BH	State	✓	n/a	2
IET-BH	State	✓	n/a	2
PCR-BH	State	✓	n/a	2
FUM	State	✓	n/a	3
FUA	State	✓	n/a	3
FUH-BH-A	State	✓	n/a	3
FUH-BH-C	State	✓	n/a	3
HOU	State	✓	n/a	3
PEC	State	✓	n/a	3
Y/FEC	State	✓	n/a	3

BHC Measures (2)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
I-EVAL	BHC	✓	n/a	4
BMI-SF	BHC	✓	n/a	4
TSC	BHC	✓	n/a	4
ASC	BHC	✓	n/a	4
CDF-BH	BHC	✓	n/a	5
WCC-BH	BHC	✓	n/a	5
SRA-BH-C	BHC	✓	n/a	5
SRA-A	BHC	✓	n/a	5
DEP-REM-12	BHC	✓	n/a	5

BHC Measures (3)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
ROUT	BHC	n/a	✓	8
TX-EVAL	BHC	n/a	✓	8
SUIC	BHC	n/a	✓	8
DOC	BHC	n/a	✓	8
CBP-BH	BHC	n/a	✓	8
SU-A	State	n/a	✓	8
APM	State	n/a	✓	8
SMC	State	n/a	✓	8
AMS-BD	State	n/a	✓	8

Contact Information

Please submit additional questions to CCBHC_Data_TA@samhsa.hhs.gov about:

- Material covered today
- Material scheduled for the next webinar
- Other questions related to data collection, analysis, or reporting

We will attempt to respond to them in the next webinar.

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